

D&S Diversified Technologies

PO Box #418, Findlay, OH 45839-0418

Toll Free 877-8512355 -- fax 419-422-8328 - www.hdmaster.com

ARIZONA MEDICATION ASSISTANT (MA)

EXAMINATION APPLICATION (forms 1101AM & 1402AM) JULY 2010

INSTRUCTIONS: (Also see www.hdmaster.com)

1. **DO NOT** mail this D&S Diversified Technologies MA Examination Application to the Arizona State Board of Nursing (AZBN)
2. **Complete** front and back sides of this MA Examination Application.
3. **Send** this completed application **with payment** to D&S Diversified Technologies, P.O. Box 418 Findlay, OH 45839-0418
4. You **must include one of the following**:
 - Proof of completion of an Arizona State Board of Nursing (AZBN) 100 hour approved MA training program (i.e. a copy of your certificate) **OR**
 - If you are a student nurse, approval must be obtained by submitting a waiver request to AZBN for approval. AZBN will notify D&S of approval **OR**
 - If you are certified/registered as a Medication Assistant in another state, approval must be obtained by submitting a waiver request to AZBN for approval. AZBN will notify D&S of approval.

NOTE: Facilities MAKE ALL CHECKS PAYABLE TO D&S DIVERSIFIED TECHNOLOGIES.
Candidate Personal checks are NOT accepted.

Before submitting this testing application, please check off the following: (Incomplete applications will be returned to applicant for completion.)

- This application is filled out **completely** (front and back) and **signed** where required.
- Exam payment** is included with the testing application.
- I have attached proof of my MA training to this application.**
- I have also completed the Arizona State Board of Nursing Application and sent that application to the AZBN.**

Candidate Information: (form 1101) Print clearly (Use Ink) or Type

Social Security No. _____ - _____ - _____ (Mandatory. Your SS number will only be shared with the Arizona State Board of Nursing)

Applicant's Name _____

_____ Last First MI Maiden/Former Name
Mailing Address (Street) _____ Apartment# _____ or PO Box # _____

City _____ State _____ County _____ Zip _____

Home Telephone _____ Message/Work Phone _____

Birth Date (Month/Day/Year) _____ / _____ / _____ E-Mail Address: _____
(Mandatory) Providing your email address is your authorization for us to use it for confirmation and results letters

I have successfully completed an AZBN approved 100 hour Medication Assistant Training Program and understand that I must pass the test within one year from the completion of my training program. If I am a certified /registered medication assistant in another state or a student nurse , and applying to test in AZ, I understand I must complete a waiver request form and receive approval from AZBN prior to taking the AZ CMA exam.

Program Code # _____ Program Name _____
(On Certificate)

City _____ Date Completed _____ Contact Person _____

If facility is paying for your test, this section must be completed by Nursing Supervisor.

Facility Name _____ Phone _____

Address _____ Contact Person _____

Signature of Nursing Supervisor _____ Date _____

I hereby declare that the above supplied information is true, complete, and accurate to the best of my knowledge. I hereby authorize release of my test results to my training program. I will honor my test appointment and agree to forfeit all test fees as payment for services provided if I do not show up for my test appointment. I will be responsible for any cancellation or rescheduling fees incurred as described in the Arizona candidate handbook.

Signature _____ Date _____

Candidate MUST sign to verify acceptance (unsigned applications will be returned) Date

Please call the Findlay office if you don't get an e-mail or mail response within ten days.

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TESTING OPTIONS: Only use Option 1 or Option 2, never both.

Testing Option 1: Regional Test Sites – Application must be received at least ten days before first requested test date.

1st Choice Test Date: (From published 1700 AM Test Schedule) **2nd Choice Test Date:** (From published 1700 AM Test Schedule)

4 Digit Test Site #	Test Site Name	4 Digit Test Site #	Test Site Name
Test Month	Test Date	Test Month	Test Date

Testing Option 2: In-Facility Test Sites

(Medication Assistant instructor must complete this section. The training program must be an AZBN/D&SDT certified test site to use this option.)

Name of Site _____ 4 Digit Test Site # _____

Contact Person _____ Phone _____

Contact Person E-Mail _____

Pre-scheduled Test Observer _____ ID# _____

Date of Testing _____ Start time for Testing: _____ AM flight start _____ PM flight start

Site Address _____ City _____ State _____ Zip Code _____

List up to twelve candidate(s) Social Security numbers for In-Facility Testing:

Exam Types and Fee Payment: (form 1402)

# Requested	Tests / Service Requested	Cost per Test	Totals
	Written test or written retake	\$25.00	
	Skill test or skill retake	\$70.00	
	Oral and Written test or retake	\$35.00	
	Priority Fax Service	\$5.00	
	Overnight Shipping	\$19.50	
	Express Service Fee	\$15.00	
	No Show	No Refund	
	Reschedule	\$35.00	

Grand Total: _____

Check method of payment: _____ Check (Facility Only) _____ Cashier's Check _____ Money Order _____ Visa _____ Master Card			
Card #: _____		Expiration Date: _____	
Authorized Signature: _____			
Print name as it appears on your credit card: _____			

ADA ACCOMMODATION

I need special accommodation under the Americans with Disabilities Act. To qualify for special accommodations, you must provide written documentation of your disability along with your application. ADA form 1404 is available at www.hdmaster.com or call D&SDT 877-851-2355.

OFFICIAL USE ONLY: Site _____	Packet# _____	Test Date _____	Scheduler _____
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